# APPENDIX J-1

## TECHNICAL GUIDELINES FOR PAPER CLAIM PREPARATION FORM HFS 1443, PROVIDER INVOICE

Please follow these guidelines in the preparation of paper claims for imaging processing to assure the most efficient processing by the department:

- Use original department issued claim form.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in capital letters. The character pitch must be 10-12 printed characters per inch, the size of most standard Pica or Elite typewriters. Handwritten entries should be avoided.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photocopying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachment with staples.

Instructions for completion of the Provider Invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

| | | |
|---|---|---|
| **Required** | = | Entry always required. |
| **Optional** | = | Entry optional – In some cases failure to include an entry will result in certain assumptions by the department and will preclude corrections of certain claiming errors by the department. |
| **Conditionally Required** | = | Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text. |
| Not Required | = | Fields not applicable. |

| **COMPLETION** | | **ITEM EXPLANATION AND INSTRUCTIONS** |
|---|---|---|
| **Required** | **1.** | **Provider Name** – Enter the provider's name exactly as it appears on the Provider Information Sheet. |
| **Required** | **2.** | **Provider Number** – Enter the provider's NPI. |
| **Required** | **3.** | **Payee** – Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet. |
| Not Required | 4. | Role – Leave Blank. |
| Not Required | 5. | Emer – Leave Blank. |
| **Conditionally Required** | **6.** | **Prior Approval** – Enter the unique number from the computer generated prior approval notification, when billing a service for which approval has been obtained. |
| **Optional** | **7.** | **Provider Street** – Enter the street address of the provider's primary office. If the address is entered, the department will, where possible, correct claims suspended due to provider errors. If address is not entered, the department will not attempt corrections. |

| | | |
|---|---|---|
| **Conditionally Required** | **8.** | **Facility & City Where Service Rendered –** This entry is required when Place of Service Code in Field 23 (Service Sections) is other than 11 (office) or 12 (home). |
| **Optional** | **9.** | **Provider City State ZIP** – Enter city, state and ZIP code of provider. See item 7 above. |
| **Required** | **10.** | **Referring Practitioner Name** – Enter the name of the physician who requested services to be provided. |
| **Required** | **11.** | **Recipient Name** – Enter the patient's name exactly as it appears on the MediPlan Card, Temporary MediPlan Card, All Kids Card or Notice of Temporary All Kids Medical Benefits. Separate the components of the name (first, middle initial, last) in the proper sections of the name field. |
| **Required** | **12.** | **Recipient No.** – Enter the nine-digit number assigned to the individual as shown on the MediPlan Card, Temporary MediPlan Card, All Kids Card or Notice of Temporary All Kids Medical Benefits. Use no punctuation or spaces. Do not use the Case Identification Number. |
| **Optional** | **13.** | **Birth Date** – Enter the month, day and year of birth of the patient as shown on the MediPlan Card, Temporary MediPlan Card, All Kids Card or Notice of Temporary All Kids Medical Benefits. Use the MMDDYYYY format. If the birth date is entered, the department will where possible, correct claims suspended due to recipient name or number errors. If the birth date is not entered, the department will not attempt corrections. |
| Not Required | 14. | H Kids – Leave Blank. |
| Not Required | 15. | Fam Plan –Leave Blank. |
| Not Required | 16. | St/Ab – Leave Blank |
| **Required** | **17.** | **Primary Diagnosis Description** – Enter the primary diagnosis that describes the condition primarily responsible to the patient's treatment. |
| **Required** | **18.** | **Primary Diag. Code** – Enter the specific ICD-9-CM, or upon implementation, ICD-10, code without the decimal for the primary diagnosis described in Item 17. |

| | | |
|---|---|---|
| **Required** | **19.** | **Taxonomy** – Enter the appropriate ten-digit HIPAA Provider Taxonomy code. Refer to Chapter 300, Appendix 5. |
| **Optional** | **20.** | **Provider Reference** – Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on Form 194-M-1, Remittance Advice, returned to the provider. |
| **Required** | **21.** | **Ref Prac No.** – Enter the NPI of the physician who requested services be provided. |
| Not Required | 22. | Secondary Diag Code – Leave blank. |
| | **23.** | **Service Sections** – Complete one Service Section for each item or service provided to the patient. |
| **Required** | | **Procedure Description/Drug Name, Form and Strength or Size** – Enter the description of the service provided or item dispensed. |
| **Required** | | **Proc. Code/NDC** – Enter the appropriate CPT code. |
| **Conditionally Required** | | **Modifiers** – Enter the appropriate two-byte modifier (s) for the service performed. The department can accept a maximum of 4 two-byte modifiers per Service Section. |
| **Required** | | **Date of Service** – Enter the date the service was provided. Use MMDDYY format. |
| **Required** | | **Cat. Serv.** – Enter the appropriate two-digit category of service code.<br>11 Physical Therapy Services<br>12 Occupational Therapy Services<br>13 Speech Therapy/Pathology Services |
| **Conditionally Required** | | **Delete** – When an error has been made that cannot be corrected, enter an "X" to delete the entire Service Section. Only the "X" will be recognized as a valid character; all others will be ignored. |

**Required**

**Place of Serv.** – Enter the two-digit Place of Service code from the following list:
11 – Office
12 – Home
13 – Assisted Living Facility
14 – Group Home
21 – Inpatient Hospital
22 – Outpatient Hospital
31 – Skilled Nursing Facility
32 – Nursing Facility
33 – Custodial Care Facility

**Required**

**Units/Quantity** – Enter the units of time covered by the therapy session. Fifteen-minute intervals equal one (1) unit. A maximum of four (4) units are allowed per date of service for therapy. A maximum of eight (8) units are allowed for children's evaluations.

Not Required

Modifying Units – Leave Blank.

**Conditionally Required**

**TPL Code** – If the patient's MediPlan or All Kids Card contains a TPL code, the code is to be entered in this field. If there is no TPL resource shown on the card, no entry is required. If more than one third party made a payment for a particular service, the additional payment(s) are to be shown in Section 25.

**Spenddown** – Refer to Chapter 100, Topic 113 for a full explanation of the Spenddown policy. The following provides examples:

When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal) attach the HFS 2432 to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields.

If Form HFS 2432 shows a recipient liability greater than $0.00 the Service Section should be coded as follows:

| | |
|---|---|
| TPL Code | 906 |
| TPL Status | 01 |
| TPL Amount | The actual recipient liability as shown on Form HFS 2432 |
| TPL Date | The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. |

If Form HFS 2432 shows a recipient liability of $0.00 the Service Section should be coded as follows:

| | |
|---|---|
| TPL Code | 906 |
| TPL Status | 04 |
| TPL Amount | 0 00 |
| TPL Date | The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. |

**Conditionally Required**

**Status** – If a TPL code is shown in the previous item, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.

The TPL Status Codes are:

**01 – TPL Adjudicated – total payment shown** – TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.

**02 – TPL Adjudicated – patient not covered** – TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.

**03 – TPL Adjudicated – services not covered** – TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.

**04 – TPL Adjudicated – spenddown met** – TPL Status Code 04 is to be entered when the patient's Form HFS 2432 shows $0.00 liability.

**05 – Patient Not Covered** – TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.

**06 – Services Not Covered** – TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.

**07 – Third Party Adjudication Pending** – TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

**10 – Deductible Not Met** – TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because

the deductible was not met.

**Conditionally Required**

**TPL Amount** – Enter the amount of payment received from the patient's third party for the service. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box. For all other Status Codes, enter 0 00. If there is no TPL code, no entry is required.

**Conditionally Required**

**TPL Date –** A TPL date is required when any status code is shown. Use the date specified below for the applicable code:

| **Status Code** | **Date to be entered** |
|---|---|
| **01** | Third Party Adjudication Date |
| **02** | Third Party Adjudication Date |
| **03** | Third Party Adjudication Date |
| **04** | Date from the HFS 2432, Split Billing Transmittal |
| **05** | Date of Service |
| **06** | Date of Service |
| **07** | Date of Service |
| **10** | Third Party Adjudication Date |

**Required**

**Provider Charge** – Enter the total charge for the service, not deducting any TPL.

Not Required 24. Optical Materials Only – Leave blank.

**Sections 25 through 30 of the Provider Invoice are to be used:** 1) to identify additional third party resources in instances where the patient has access to two or more resources and 2) to calculate total and net charges.

If an additional third party resource was identified for one or more of the services billed in Service Sections 1 through 6 of the Provider Invoice, complete the TPL fields in accordance with the following instructions.

**Conditionally Required** **25. Sect. # –** If more than one third party made a payment for a particular service, enter the Service Section number (1 through 6) in which that service is reported.

If a third party made a single payment for several services and did not specify the amount applicable to each, enter the Number 0 (zero) in this field. When 0 is entered, the third party payment shown in section 25C will be applied to the total of all Service Sections on the Provider Invoice.

**Conditionally Required** **25A. TPL Code –** Enter the appropriate TPL Code referencing the source of payment (Chapter 100, General Appendix 9). If the TPL Codes are not appropriate enter 999 and enter the name of the payment source in Section 35.

**Conditionally Required** **25B. Status** – Enter the appropriate TPL Status Code. See the Status field in Item 23 above for correct coding of this field.

**Conditionally Required** **25C. TPL Amount** – Enter the amount of payment received from the third party resource.

**Conditionally Required** **25D. TPL Date –** Enter the date the claim was adjudicated by the third party resource. (See the TPL Date field in Item 23 above for correct coding of this field.)

**Conditionally Required** **26. Sect. #** – Enter (See 25 above).

**Conditionally Required** **26A. TPL Code** – (See 25A above.)

**Conditionally Required** **26B. Status** – (See 25B above).

**Conditionally Required** **26C. TPL Amount** – (See 25C above).

**Conditionally Required** **26D. TPL Date –** (See 25D above).

**Conditionally Required** **27. Sect.** – (See 25 above).

**Conditionally Required** **27A. TPL Code** – (See 25A above).

**Conditionally Required** **27B. Status** – (See 25B above).

**Conditionally Required** **27C. TPL Amount** – (See 25C above).

**Conditionally Required** **27D. TPL Date** – (See 25D above).

**Claim Summary Fields**: The three claim summary fields must be completed on all Provider Invoices. These fields are Total Charge, Total Deductions and Net Charge. They are located at the bottom far right of the form.

| | | |
|---|---|---|
| **Required** | **28.** | **Tot Charge** – Enter the sum of all charges submitted on the Provider Invoice in Service Sections 1 through 6. |
| **Required** | **29.** | **Tot Deductions** – Enter the sum of all payments submitted in the TPL Amount field in the Service Sections 1 through 6. If no payment was received, enter zeroes (0 00). |
| **Required** | **30.** | **Net Charge** – Enter the difference between Total Charge and Total Deductions. |
| **Required** | **31.** | **# Sects** – Enter the total number of Service Sections completed in the top part of the form. This entry must be at least one and no more than six. Do not count any sections that were deleted because of errors. |
| Not Required | 32. | Original DCN – Leave blank. |
| Not Required | 33. | Sect. – Leave blank. |
| Not Required | 34. | Bill type – Leave blank. |
| **Conditionally Required** | **35.** | **Uncoded TPL Name** – Enter the name of the third party resource. The name must be entered if TPL code 999 is used. |
| **Required** | **36-37** | **Provider Certification, Signature and Date** – After reading the certification statement, the provider or their designee must sign the completed form. The signature must be handwritten in black ink. A stamped or facsimile signature is not acceptable. Unsigned Provider Invoices will be rejected. The signature date is to be entered in MMDDYY format. |

# MAILING INSTRUCTIONS

The Provider Invoice is a single page or two-part form. The provider is to submit the original of the form to the department as indicated below. The pin-feed guide strip of the two-part continuous feed form should be removed prior to submission to the department. The copy of the claim should be retained by the provider.

Routine claims are to be mailed to the department in pre-addressed mailing envelopes, HFS 1444, Provider Invoice Envelope, provided by the department.

Mailing address: Healthcare and Family Services
P.O. Box 19105
Springfield, Illinois 62794-9105

Non-routine claims (claims with attachments, such as EOB or split bill transmittals (HFS 2432) are to be mailed to the department in a pre-addressed mailing envelope, Form HFS 2248, NIPS Special Invoice Handling Envelope, which is provided by the department for this purpose.

Mailing address: Healthcare and Family Services
P.O. Box 19118
Springfield, Illinois 62794-9118

Forms Requisition:

Billing forms may be requested on our Web site at: http://www.hfs.illinois.gov/forms/ or by submitting a HFS 1517 as explained in Chapter 100, General Appendix 10.

# APPENDIX J-1a

## TECHNICAL GUIDELINES FOR PAPER CLAIM PREPARATION FORM HFS 3797, MEDICARE CROSSOVER INVOICE

To assure the most efficient processing by the department, please follow these guidelines in the preparation of paper claims for image processing:

- Use original department issued claim form.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image and will be returned to the provider.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in capital letters. The character pitch must be 10-12 printed characters per inch, the size of most standard Pica or Elite typewriters. Handwritten entries should be avoided.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- Print in the gray area of attachments, either as part of the original or as a result of photocopying a colored background, is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachment with staples.

**Do not attach a copy of the Explanation of Medicare Benefits (EOMB) when billing on the HFS 3797.**

Instructions for completion of this invoice follow in the order that entries appear on the form. Mailing instructions follow the claim preparation instructions. **If billing for a Medicare denied or disallowed service, bill on the appropriate HFS Medicaid form.**

MediPlan Card – the identification card issued monthly by the department to each person or family who is eligible under Medical Assistance, Transitional Assistance (City of Chicago), State Family and Children Assistance (City of Chicago) All Kids Assist or All Kids Moms and Babies, and for Qualified Medicare Beneficiary (QMB) who is not eligible for Medical Assistance, but is eligible for department consideration of Medicare coinsurance and deductibles.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

| | | |
|---|---|---|
| **Required** | = | Entry always required. |
| **Optional** | = | Entry optional – In some cases failure to include an entry will result in certain assumptions by the department and will preclude corrections of certain claiming errors by the department. |
| **Conditionally Required** | = | Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text. |

| **COMPLETION** | **ITEM EXPLANATION AND INSTRUCTIONS** |
|---|---|
| **Required** | **Claim Type** – Enter a capital "X" in the appropriate box, using the following guideline when determining claim type:<br>23 - Practitioner – physicians, optometrists, podiatrists, therapists, audiologists, hospitals (fee-for-service), RHC, FQHC, Imaging Centers<br>24 - Dental – dental providers<br>25 - Lab/Port X-Ray – all laboratories and portable X-ray providers<br>26 - Med. Equip/Supply – medical equipment and supply providers, pharmacies<br>28 – Transportation – ambulance service providers (previously billed on HCFA 1491)<br><br>If provider type is not indicated above, enter a capital "X" in the Practitioner box. |
| **Required** | **1. Recipient's Name** - Enter the recipient's name (first, middle, last) exactly as it appears on the back of the MediPlan card. |
| **Required** | **2. Recipient's Birth Date** - Enter the month, day and year of birth. Use the MMDDYY format. |

**Required** **3. Recipient's Sex** – Enter a capital "X" in the appropriate box.

**Conditionally Required** **4. Was Condition Related to** –

**A.** Recipient's Employment - Treatment for an injury or illness that resulted from recipient's employment, enter a capital "X" in the "Yes" box.

**B.** Accident - Injury or a condition that resulted from an accident, enter a capital "X" in Field B, Auto or Other as appropriate.

Any item marked "Yes" indicates there may be other insurance primary to Medicare. Identify primary insurance in Field 9.

**Required** **5. Recipient's Medicaid Number** – Enter the individual's assigned nine-digit number from the MediPlan Card. Do not use the Case Identification Number.

**Required** **6. Medicare HIC (Health Insurance Claim) Number** – Enter the Medicare Health Insurance Claim Number (HICN).

**Required** **7. Recipient's Relation to Insured** – Enter a capital "X" in the appropriate box.

**Required** **8. Recipient's or Authorized Person's Signature** – The recipient or authorized representative must sign and enter a date unless the signature is on file with the provider/supplier. **If the signature is on file, enter the statement "Signature on File" here**.

**Conditionally Required** **9. Other Health Insurance Information** - If the recipient has an additional health benefit plan, enter a capital "X" in the "YES" box. Enter Insured's Name, Insurance Plan/Program Name And Policy/Group No., as appropriate.

**Required** **10A. Date(s) of Service** - Enter the date(s) of service submitted to Medicare. Use MMDDYY format in the "From" and "To" fields.

**Required** **10B. P.O.S. (Place of Service)** – Enter the two-digit POS code submitted to Medicare.

Not Required 10C. T.O.S. (Type of Service) – Leave blank.

| | | |
|---|---|---|
| **Required** | **10D.** | **Days or Units** – Enter the number of services (NOS) shown on the Explanation of Medicare Benefits (EOMB). All entries must be four digits, i.e., 0001.<br><br>Mileage – Enter the total number of miles as shown on the Explanation of Medicare Benefits (EOMB). All entries must be in a four-digit format; the entry for 32 miles is 0032.<br><br>Anesthesia or Assistant Surgery Services– Enter the total number of units as shown on the Explanation of Medicare Benefits (EOMB). All entries must be in a four-digit format; the entry for 1 unit is 0001. |
| **Required** | **10E.** | **Procedure Code** - Enter the procedure code adjudicated by Medicare shown on the Explanation of Medicare Benefits (EOMB). |
| **Required** | **10F**. | **Amount Allowed** – Enter the amount allowed by Medicare for the service(s) provided as shown on the Explanation of Medicare Benefits (EOMB). |
| **Required** | **10G.** | **Deductible** – Enter the deductible amount for service(s) as shown on the Explanation of Medicare Benefits (EOMB). |
| **Required** | **10H.** | **Coinsurance** – Enter the coinsurance amount for service(s) as shown on the Explanation of Medicare Benefits (EOMB). |
| **Required** | **10I.** | **Provider Paid** – Enter the amount the provider was paid by Medicare as shown on the Explanation of Medicare Benefits (EOMB). |
| **Conditionally Required** | **11.** | **For NDC Use Only** – Required when billing NDC codes for pharmacy/physician claims. |
| **Conditionally Required** | **12.** | **For Modifier Use Only** – Enter HCPCS or CPT modifiers for the procedure code entered in Field 10E as shown on the Explanation of Medicare Benefits (EOMB). |
| Not Required | 13A. | Origin of Service – Leave blank. |
| Not Required | 13B. | Modifier –Leave blank. |
| Not Required | 14A. | Destination of Service – Leave blank. |
| Not Required | 14B. | Modifier – Leave blank. |
| Not Required | 15A. | Origin of Service – Leave blank. |

Not Required 15B. Modifier – Leave blank.

Not Required 16A. Destination of Service – Leave blank.

Not Required 16B. Modifier – Leave blank.

**Optional** **17. ICN #** - Enter the Medicare Invoice Control Number, Patient Account Number or Provider Reference Number. This field can accommodate up to 20 numbers or letters. If this field is completed, the same data will appear on Form HFS 194-M-1, Remittance Advice, returned to the provider.

**Conditionally Required** **18. Diagnosis or Nature of Injury or Illness** – Enter the description of the diagnosis or nature of injury or illness that describes the condition primarily responsible for the recipient's treatments. A written description is not required if a valid ICD-9-CM, or upon implementation, ICD-10, code is entered in Field 18A.

**Required** **18A. Primary Diagnosis Code** – Enter the valid ICD-9-CM, or upon implementation, ICD-10, diagnosis code for the services rendered.

**Optional** **18B**. **Secondary Diagnosis Code** – A secondary diagnosis may be entered if applicable. Enter only a valid ICD-9-CM, or upon implementation, ICD-10, diagnosis code.

**Required** **19. Medicare Payment Date** – Enter the date Medicare made payment. This date is located on the Explanation of Medicare Benefits (EOMB). Use MMDDYY format.

**Conditionally Required** **20. Name and Address of Facility Where Services Rendered** This entry is required when Place of Service (10B) is other than provider's office or recipient's home. Enter the facility name and address where the service(s) was furnished. When the name and address of the facility where the services were furnished is the same as the biller's name and address as submitted in Field 22, enter the word "Same."

**Required** **21. Accept Assignment** – The provider must accept assignment of Medicare benefits for services provided to recipients for the department to consider payment of deductible and coinsurance amounts. Enter a capital "X" in the "Yes" box if accepting assignment.

**Required** **22. Physician/Supplier Name, Address, City, State, ZIP Code**– Enter the physician/supplier name exactly as it appears on the Provider Information Sheet under "Provider

Key."

**Required** **23. HFS Provider Number** – Enter the Provider's NPI.

**Required** **24. Payee Code** – Enter the single-digit number of the payee to whom the payment is to be sent. Payees are coded numerically on the Provider Information Sheet.

**Conditionally Required** **25. Name of Referring Physician or Facility** – Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

Referring Physician – a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering Physician – A physician who orders non-physician services for the Recipient such as diagnostic tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.

**Conditionally Required** **26. Identification Number of Referring Physician** – All claims for Medicare covered services, and items that are a result of a physician's order or referral, must include the ordering/referring physician's NPI number.

Not Required 27. Medicare Provider ID Number – Enter the carrier assigned Provider Identification Number (PIN) for the performing provider of service/supply.

**Required** **28. Taxonomy Code** - Enter the appropriate ten-digit HIPAA Provider Taxonomy code.

**Conditionally Required** **29A. TPL Code** – The TPL Code contained on the Recipient's MediPlan Card is to be entered in this field. If payment was received from a third party resource not listed on the MediPlan Card, enter the appropriate TPL Code as listed in Chapter 100, General Appendix 9. If none of the TPL codes in the General Appendix 9 are applicable to the source of payment, enter code "999." If more than one third party made a payment for a particular service, the additional payment is to be shown in Fields 30A – 30D.

**Conditionally Required**

**29B. TPL Status** – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. The TPL Status Codes are:

**01 – TPL Adjudicated – total payment shown:** TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.
**02 – TPL Adjudicated – patient not covered:** TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.
**03 – TPL Adjudicated – services not covered:** TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.
**04 – TPL Adjudicated – spenddown met:** TPL Status Code 04 is to be entered when the patient's Form HFS 2432 shows $0.00 liability.
**05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.
**06 – Services not covered:** TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.
**07 – Third Party Adjudication Pending:** TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.
**10 – Deductible not met:** TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

**Conditionally Required**

**29C. TPL Amount** – Enter the amount of payment received from the third party resource. If there is no TPL amount, enter $0.00. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" field.

**Conditionally Required**

**29D. TPL Date –** A TPL date is required when any status code is shown in Field 29B. Use the date specified below for the applicable TPL status code. Use the MMDDYY format.

| Status Code | Date to be entered |
|---|---|
| 01 | Third Party Adjudication Date |
| 02 | Third Party Adjudication Date |
| 03 | Third Party Adjudication Date |
| 04 | Date from the HFS 2432 |
| 05 | Date of Service |
| 06 | Date of Service |
| 07 | Date of Service |
| 10 | Third Party Adjudication Date |

**Conditionally Required**

**30A. TPL Code** – (See 29A above).

**Conditionally Required**

**30B. TPL Status** – (See 29B above).

**Conditionally Required**

**30C. TPL Amount** – (See 29C above).

**Conditionally Required**

**30D. TPL Date** – (See 29D above).

**Required**

**31. Provider Signature** - After reading the certification statement printed on the back of the claim form, the provider or authorized representative must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Unsigned claims will not be accepted by the department and will be returned to the provider. The provider's signature should not enter the date section of this field.

**Required**

**32. Date** – The date of the provider's signature is to be entered in the MMDDYY format.

## MAILING INSTRUCTIONS

The Medicare Crossover Invoice is a single page or two-part continuous feed form. The provider is to submit the original of the form to the department as indicated below. The pin-feed guide strip of the two-part continuous feed form should be removed prior to submission to the department. The yellow copy of the claim should be retained by the provider.

Invoices are to be mailed to the department in the pre-addressed mailing envelopes, Form HFS 824MCR, Medicare Crossover Invoice Envelope, provided by the department. Should envelopes be unavailable, the HFS 3797 (Medicare Crossover Invoice) can be mailed to:

Medicare Crossover Invoice
Healthcare and Family Services
Post Office Box 19109
Springfield, Illinois 62794-9109

Do not bend or fold claims prior to submission.

Forms Requisition - Billing forms may be requested on our Web site at http://www.hfs.illinois.gov/forms/ or by submitting a HFS 1517 as explained in Chapter 100, General Appendix 10.

# APPENDIX J-2

# PREPARATION AND MAILING INSTRUCTIONS FOR FORM HFS 1409, PRIOR APPROVAL REQUEST

Form HFS 1409, Prior Approval Request, is to be submitted by the provider for certain specified services in order for the services to qualify for reimbursement. Services and items requiring prior approval are identified in this handbook.

Form HFS 1409 is a multi-part form. A sample of the form may be found on the department's Web site at: http://www.hfs.illinois.gov/medicalforms/

## INSTRUCTIONS FOR COMPLETION

The form is to be typewritten or legibly hand printed. Instructions for completion follow in the order entries appear on the form. Mailing instructions follow the form preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

| | | |
|---|---|---|
| **Required** | = | Entry always required. |
| **Conditionally Required** | = | Entries that are required only under certain circumstances. Conditions of the requirement are identified in the instruction text. |
| Not Required | = | Fields not applicable; leave blank. |

| COMPLETION | | ITEM EXPLANATION AND INSTRUCTIONS |
|---|---|---|
| Not Required | 1. | Trans Code (Transaction Code) – Leave blank. |
| Not Required | 2. | Prior Approval Number – Leave blank. |
| Not Required | 3. | Case Name – Leave blank. |
| **Required** | **4.** | **Recipient Name** – Enter the name of the patient for whom the service is requested, exactly as it appears on the MediPlan or All Kids card. |
| **Required** | **5.** | **Recipient Number** – Enter the nine-digit Recipient Identification Number assigned to the patient for whom the service is requested. This number is found to the right of the |

patient's name on the back of the MediPlan or All Kids card.

| | | |
|---|---|---|
| **Required** | **6.** | **Birth Date** – Enter the patient's birthdate. This is a six-digit field. Entry must be in MMDDYY format, with no commas or dashes. For example, a birthdate of February 3, 2001 would be entered as 020301. |
| Not Required | 7. | Inst Set (Institutional Setting) – Leave blank. |
| Not Required | 8. | Case Number – Leave blank. |
| Not Required | 9. | Recipient Street – Leave blank. |
| Not Required | 10. | Facility Name – Leave blank. |
| Not Required | 11. | Recipient City – Leave blank. |
| Not Required | 12. | Facility City –Leave blank. |
| **Required** | **13.** | **Requesting Provider Name** – Enter the name of the physician who is requesting the service. |
| **Required** | **14.** | **Request Prov. No. (Requesting Provider Number)** – Enter the state medical license number, UPIN, Social Security number or NPI number of the physician/practitioner who has ordered therapy services. |
| Not Required | 15. | Provider Street – Leave blank. |
| Not Required | 16. | Provider Telephone – Leave blank. |
| Not Required | 17. | Provider City, State, Zip – Leave blank. |
| **Required** | **18.** | **Supplying Provider Name** – Enter the supplying provider's name. |
| **Required** | **19.** | **Supply Prov. No. (Supplying Provider Number)** – Enter the supplying provider's Provider or NPI number exactly as shown on the Provider Information Sheet. Use no punctuation or spaces. |
| **Required** | **20.** | **Provider Street** – Enter the supplying provider's address. |

| | | |
|---|---|---|
| **Required** | **21.** | **Provider Telephone** – Enter the telephone number of the supplying provider's office. This information is helpful in instances where the department needs additional information in order to act upon the request. |
| **Required** | **22.** | **Provider City, State, Zip** – Refer to Item 20 above. |
| Not Required | 23. | Aprv. Authorit (Approving Authority) – Leave blank. |
| Not Required | 24. | Disp. Date – Leave blank. |
| Not Required | 25. | Approving Authority Signature – Leave blank. |
| Not Required | 26. | Receipt – Leave blank. |
| **Required** | **27.** | **SERVICE SECTIONS** – The form provides space to request a maximum of three services. When more than three services are requested, a second form must be completed. Instructions for completion of entry fields contained within a service section follow: |
| **Required** | | **Req Proc No. (Requested Procedure Code)** – Enter the code that identifies the procedure for which approval is requested. |
| **Required** | | **Req Qty (Requested Quantity)** – Enter the number of units requested. 1 unit = 15 mins. |
| Not Required | | Prov Charge (Provider Charge) –Leave blank. |
| **Required** | | **Cat. Serv (Category of Service)** – Enter two-digit code.<br>11= Physical Therapy<br>12= Occupational Therapy<br>13= Speech Therapy |
| **Required** | | **Description** – Briefly describe the services or items to be provided. Enter frequency, duration and service time frames with begin and end dates. |
| Not Required | | All remaining items in each service section are for department use only. Leave blank. |
| **Conditionally Required** | **28.** | **Medical Necessity** – Enter additional information/reason for service. |
| **Required** | **29.** | **Supplying Provider Signature** – The form must be signed by the individual who is to provide the service. |

**Required** **30. Request Date –** Enter the date the form is signed.

**Required Attachments:**
Current physician's order signed by a physician (M.D. or D.O.), advanced practice nurse or physician assistant.
Copy of initial evaluation or progress summary (for recertifications)

## MAILING INSTRUCTIONS

Before mailing, carefully review the request for completeness and accuracy. The top, signed copy of the request is to be mailed to:

Healthcare and Family Services
Bureau of Comprehensive Health Services
Post Office Box 19124
Springfield, IL 62794-9124

The remaining copies may be retained in the provider's records.

A notification of approval or denial of the service(s) will be mailed to the provider. The service is not to be billed until the approval notification is received.

# APPENDIX J-3

## EXPLANATION OF INFORMATION ON PROVIDER INFORMATION SHEET

The Provider Information Sheet is produced when a provider is enrolled in the department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign and date your signature on the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic J-201.2 for instructions.) If all the information noted on the sheet is correct, the provider is to keep the document and reference it when completing any department forms.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix J-3a. The item numbers that correspond to the explanations below appear in small circles ◯ on the sample form.

| FIELD | EXPLANATION |
|---|---|
| (1) **Provider Key** | This number uniquely identifies the provider and is used internally by the department. It is directly linked to the reported NPI shown in Field 8. |
| (2) **Provider Name And Location** | This area contains the **Name and Address** of the provider as carried in the department's records. The three-digit **County** code identifies the county in which the provider maintains his primary office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The **Telephone Number** is the primary telephone number of the provider's primary office. |
| (3) **Enrollment Specifics** | This area contains basic information concerning the provider's enrollment with the department.<br><br>**Provider Type** is a three-digit code and corresponding narrative that indicates the provider's classification.<br><br>**Organization Type** is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are: |

01 = Individual Practice
02 = Partnership
03 = Corporation
04 = Group Practice

**Enrollment Status** is a one-digit code and corresponding narrative that indicates whether or not the provider is currently an active participant in the department's Medical Programs. The possible codes are:

B = Active
I = Inactive
N = Non Participating

Disregard the term MOCST if it appears in this term.

Immediately following the enrollment status indicator are the **Begin** date indicating when the provider was most recently enrolled in the department's Medical Programs and the **End** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **End** date field.

**Exception Indicator** may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are:

A = Exception Requested by Audits
C = Citation to Discover Assets
G = Garnishment
S = Exception Requested by Provider Participation Unit
T = Tax Levy

If this item is blank, the provider has no exception.

Immediately following the **Exception Indicator** are the **Begin** date indicating the first date when the provider's claims are to be manually reviewed and the **End** date indicating the last date the provider's claims are to be manually reviewed. If the provider has no exception, the date fields will be blank.

**AGR** (Agreement) indicates whether the provider has a form HFS 1413 (Provider Agreement) on file. If the value of the field is yes, the provider is eligible to submit claims electronically.

4 **Certification/ License Number**

This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **Ending** date indicating when the license will expire.

5 **S.S.#**

This is the provider's Social Security or FEIN number.

6 **Categories of Service**

This area identifies the types of services, procedure(s) and current rate a provider is enrolled to provide.

**PROCEDURE CODE** - Identifies and defines the specific procedure(s) codes the provider is enrolled to perform. Immediately following the procedure description is the **DATE** the provider has been approved to render services and the reimbursable **RATE** approved by the department for each listed service rendered by the provider.

**ELIGIBILITY CATEGORY OF SERVICE** contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the department's Medical Programs. The possible codes are:

011 – Physical Therapy Services
012 – Occupational Therapy Services
013 – Speech Therapy/Pathology Services

Each entry is followed by the date that the provider was approved to render services for each category listed.

7 **Payee Information**

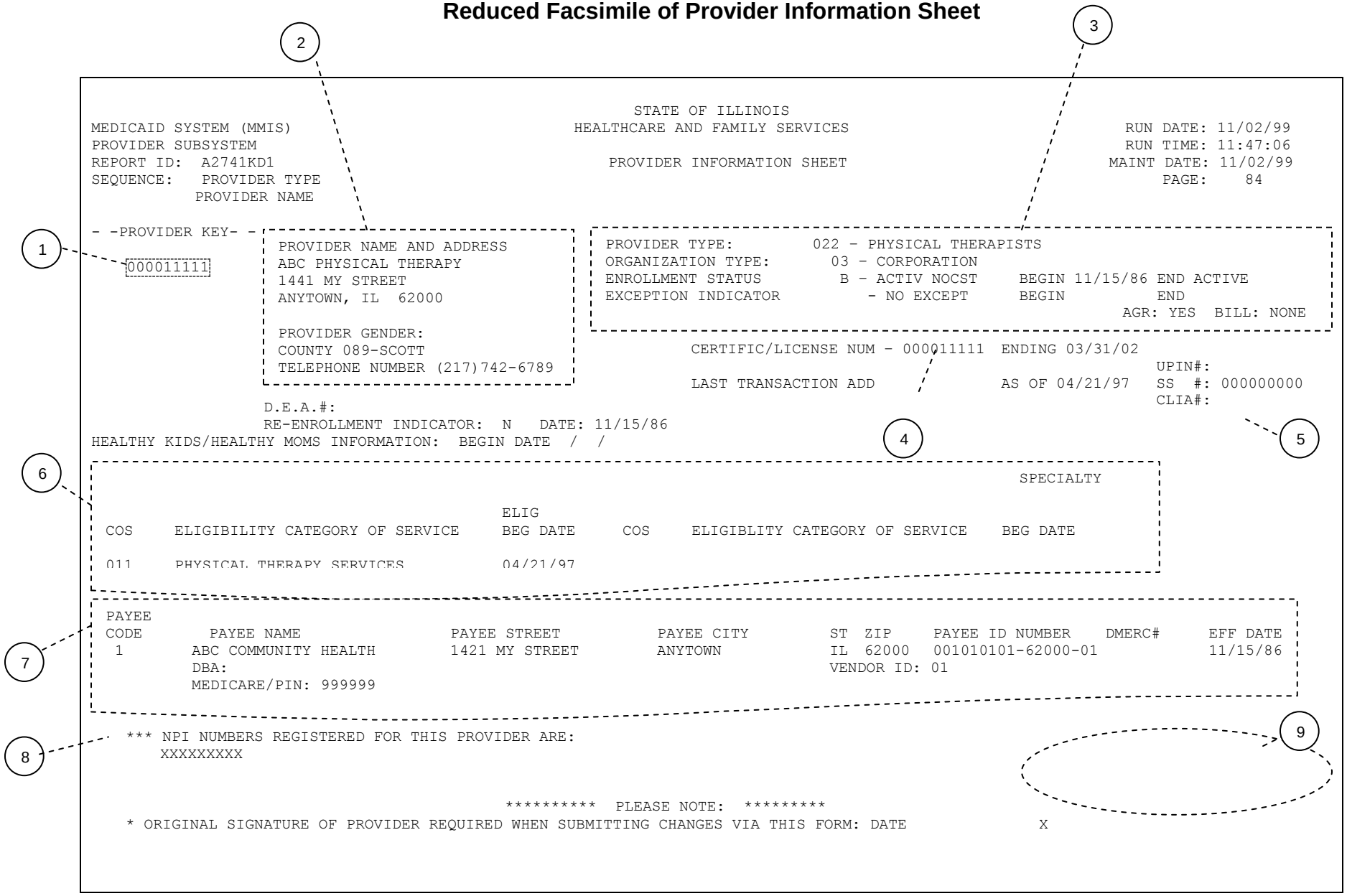
This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single-digit **Payee Code,** which is to be used on the claim form to designate the payee to whom the warrant is to be paid.

If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.

**Payee ID Number** is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes; therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.

| | |
|---|---|
| | The **Medicare/PIN** or the **DMERC #** is the number assigned to the payee by the Medicare Carrier to crossover Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable. |
| (8) **NPI** | The National Provider Identification Number contained in the department's provider database. |
| (9) **Signature** | The provider is required to affix an original signature when submitting charges to the Department of Healthcare and Family Services. |

# APPENDIX J-3a
## Reduced Facsimile of Provider Information Sheet



STATE OF ILLINOIS
MEDICAID SYSTEM (MMIS) HEALTHCARE AND FAMILY SERVICES RUN DATE: 11/02/99
PROVIDER SUBSYSTEM RUN TIME: 11:47:06
REPORT ID: A2741KD1 PROVIDER INFORMATION SHEET MAINT DATE: 11/02/99
SEQUENCE: PROVIDER TYPE PAGE: 84
PROVIDER NAME

- -PROVIDER KEY- -
0000111111

PROVIDER NAME AND ADDRESS
ABC PHYSICAL THERAPY
1441 MY STREET
ANYTOWN, IL 62000

PROVIDER GENDER:
COUNTY 089-SCOTT
TELEPHONE NUMBER (217)742-6789

PROVIDER TYPE: 022 – PHYSICAL THERAPISTS
ORGANIZATION TYPE: 03 – CORPORATION
ENROLLMENT STATUS B – ACTIV NOCST BEGIN 11/15/86 END ACTIVE
EXCEPTION INDICATOR - NO EXCEPT BEGIN END
AGR: YES BILL: NONE

CERTIFIC/LICENSE NUM – 0000111111 ENDING 03/31/02
UPIN#:
LAST TRANSACTION ADD AS OF 04/21/97 SS #: 000000000
CLIA#:

D.E.A.#:
RE-ENROLLMENT INDICATOR: N DATE: 11/15/86
HEALTHY KIDS/HEALTHY MOMS INFORMATION: BEGIN DATE / /

| COS | ELIGIBILITY CATEGORY OF SERVICE | ELIG BEG DATE | COS | ELIGIBLITY CATEGORY OF SERVICE | BEG DATE |
|---|---|---|---|---|---|
| 011 | PHYSICAL THERAPY SERVICES | 04/21/97 | | | |

SPECIALTY

| PAYEE CODE | PAYEE NAME | PAYEE STREET | PAYEE CITY | ST | ZIP | PAYEE ID NUMBER | DMERC# | EFF DATE |
|---|---|---|---|---|---|---|---|---|
| 1 | ABC COMMUNITY HEALTH<br>DBA:<br>MEDICARE/PIN: 999999 | 1421 MY STREET | ANYTOWN | IL<br>VENDOR ID: 01 | 62000 | 001010101-62000-01 | | 11/15/86 |

*** NPI NUMBERS REGISTERED FOR THIS PROVIDER ARE:
XXXXXXXXX

********** PLEASE NOTE: *********
* ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE X

1
2
3
4
5
6
7
8
9

# APPENDIX J-4

## INITIAL TREATMENT WITHOUT PRIOR APPROVAL FOR PHYSICAL AND OCCUPATIONAL THERAPY

The following is a list of diagnoses and time for initial treatment without prior approval.

Services for these conditions may be provided during the time or the number of treatments identified, whichever occurs first.

If service is necessary beyond the time or number listed, prior approval will be necessary.

Along with the appropriate diagnosis, the therapist must ensure that a functional deficit exists which impairs the participant's physical well-being and that therapy services have the capacity to alleviate or significantly reduce such deficit, and that without therapy services the participant's functional deficit would not improve.

| Diagnosis/Etiology | Initial Time | Number of Sessions |
|---|---|---|
| Fracture of vertebral column | 1 month | 8 |
| Incomplete Cauda Equina syndrom | 3 months | 39 |
| Spinal radiculopathy | 3 months | 39 |
| Spinal Stenosis | 3 months | 39 |
| AIDS w/neurological impairment | 3 months | 26 |
| Amyotropic Lateral Sclerosis | 3 months | 26 |
| Cerebellar Ataxia | 3 months | 26 |
| Diabetes w/neurological impairment | 3 months | 26 |
| Encephalopathy | 3 months | 26 |
| Gullain Barre Syndrome | 3 months | 26 |
| Postpolio Syndrome | 3 months | 26 |
| Meningitis | 3 months | 26 |
| Multiple Sclerosis | 3 months | 26 |
| Myasthenia Gravis | 3 months | 26 |

| **Diagnosis/Etiology** | **Initial Time** | **Number of Sessions** |
|---|---|---|
| Parkinsons disease | 3 months | 26 |
| Spinocerebellar degeneration | 3 months | 26 |
| Syringomyelia | 3 months | 26 |
| Quadraplegia | 3 months | 39 |
| Cerebrovascular accident | 3 months | 39 |
| Hemiparesis | 3 months | 39 |
| Hemiplegia | 3 months | 39 |
| Subarachniod hemorrhage | 3 months | 39 |
| Ankylosing Spondylitis | 3 months | 39 |
| Degenerative joint disease | 3 months | 39 |
| Dermatomyocitis | 3 months | 39 |
| Juvenile Rheumatoid Arthritis | 3 months | 39 |
| Lupus Erythematosis | 3 months | 39 |
| Osteoarthritis | 3 months | 39 |
| Psoriatic Arthritis | 3 months | 39 |
| Rheumatoid Arthritis | 3 months | 39 |
| Scleraderma | 3 months | 39 |
| Amputation (upper or lower extremity) | 3 months | 39 |
| Multiple fractures (upper or lower extremity) | 3 months | 39 |
| Adhesive capsulitis of shoulder | 3 months | 39 |
| Brachial Plexus lesion | 3 months | 39 |
| Compression syndrome | 3 months | 39 |

| **Diagnosis/Etiology** | **Initial Time** | **Number of Sessions** |
|---|---|---|
| Upper extremity joint contracture | 3 months | 39 |
| Crushing injury | 3 months | 39 |
| Degloving injury | 3 months | 39 |
| DeQuervian's disease | 3 months | 39 |
| Dupuytren's Paralysis | 3 months | 39 |
| Erbs Palsy | 3 months | 39 |
| Klumpkes Paralysis | 3 months | 39 |
| Peripheral nerve injury | 3 months | 39 |
| Reflex Sympathetic Dystrophy | 3 months | 39 |
| Muscle rupture | 3 months | 39 |
| Shoulder (glenhumeral fracture) | 3 months | 39 |
| Single fracture (wrist, upper or lower arms) | 3 months | 39 |
| Tendon repair | 3 months | 26 |
| Tendonitis | 3 months | 26 |
| Carpel Tunnel Syndrome | 3 months | 26 |
| Commulative trauma | 3 months | 39 |
| Lymphedema | 3 months | 39 |
| Rotator cuff | 3 months | 39 |
| Shoulder dislocation | 3 months | 39 |
| Facial and trunk burns | 3 months | 39 |
| Facial and trunk reconstructive surgery | 3 months | 39 |
| Arthrogyposis | 3 months | 39 |
| Hypertonia | 3 months | 39 |

| **Diagnosis/Etiology** | **Initial Time** | **Number of Sessions** |
|---|---|---|
| Hypotonia | 3 months | 39 |
| Muscular Dystrophy | 3 months | 39 |
| Sensory Integrative Dysfunction | 3 months | 39 |
| Anoxic Brain Injury | 3 months | 39 |
| Brain tumor | 3 months | 39 |
| Closed head injury | 3 months | 39 |
| Central cord syndrome | 3 months | 39 |
| Quadriplegia, quadriparesis | 3 months | 39 |
| Paraplegia, paraparesis | 3 months | 39 |
| Upper extremity burns | 3 months | 39 |
| Upper extremity reconstructive surgery | 3 months | 39 |

# APPENDIX J-5

## GUIDELINES FOR SERVICE NOT REQUIRING PRIOR APPROVAL FOR SPEECH AND LANGUAGE THERAPY

## ADULT NEUROLOGICAL DISORDERS

### A. DESCRIPTIONS

1. **APHASIA:** An impairment in understanding and use of language. Disturbances may be evident in speech, auditory comprehension, reading, writing, gestures or numerical relationships. It is unrelated to any speech muscle dysfunction.

   **Etiology:** A result of brain damage from stroke (Cerebral Vascular Accident), head injury, tumors and infection such as meningitis.

2. **APRAXIA:** An impairment of voluntary movements on command due to brain damage in the absence of significant auditory comprehension deficits and not the result of neuromuscular impairment. This category includes:

   a. MOTOR APRAXIA: An impairment in the ability to carry out voluntary motor acts such as writing, gesturing, and use of objects, etc.

   b. APRAXIA OF SPEECH: An impairment of controlled voluntary movement of the speech mechanism that verbal expression is usually labored and person may appear to struggle when speaking. Sounds are not always produced accurately.

   **Etiology:** It is a result of brain damage caused by stroke (CVA), head injury, infection or tumor.

3. **DYSARTHRIA:** A motor speech impairment due to paralysis, weakness or incoordination of the muscles of speech, phonation and respiration.

   **Etiology:** Dysarthria is the result of damage to the speech muscle control centers in the brain caused by stroke (CVA), head trauma, tumors or diseases affecting muscle control which include, but are not limited to: Cerebral Vascular Accident, Amyotrophic Lateral Sclerosis, Cerebral Palsy, Multiple Sclerosis, exposure to toxins and drugs, Parkinson's Disease, Myasthenia Gravis and Polio.

4. **NON-DOMINANT HEMISPHERE LESIONS:** Difficulty in utilizing language skills effectively and efficiently. Problems in the area of attention, orientation, perception, pragmatics, memory and integration affect the patient's ability to understand, read, write, speak, handle money and perform mathematical calculations.

**Etiology**: It is a result of brain damage caused by stroke (CVA), head injury, tumor or infection. The damage occurs on the non-dominant side of the brain, which in most adults is the right cerebral hemisphere

5. **LANGUAGE DEFICITS RELATED TO GENERALIZED BRAIN DAMAGE:** Overall depressed language skills with attentional and memory deficits; disorientation to time, person and place; problems with abstract language and reduced ability to organize language and slow processing.

   **Etiology:** It is a result of brain damage caused by, but not limited to anoxia, encephalitis, multiple CVA's, toxicity, carbon monoxide poison, Parkinson's disease, dementia, Alzheimer's Disease, organic brain syndrome, Korsakoff's Disease, head injury, etc.

## B. CRITERIA FOR TREATMENT

Assessment/Evaluation by a licensed speech-language pathologist or CFY reveals:

1. Functional deficits in auditory comprehension, speech-language production, reading, numerical relationships, writing or pragmatics,
2. Potential for improvement,
3. No previous outpatient treatment for the most recent episode, or
4. A significant circumstance necessitating a second treatment regimen, including, but not limited to: patient showed significant increase in alertness, motivation or language functioning, treatment course interrupted, etc.

## C. LENGTH OF TREATMENT

Initial Treatment Period (up to 6 months):

1. No prior approval.
2. 30, individual or group, one-hour sessions

Additional treatment period after reassessment (up to 6 months for each period):

1. Prior approval.
2. 30, individual or group, one-hour sessions

# ADULT VOICE DISORDERS
# GENERAL

## A. DESCRIPTION

Voice disorders in adults and adolescents can include problems of vocal quality, resonance, pitch or loudness. Aphonia (the absence of voice) and aphonic breaks can occur. There can also be breath support/control problems impairing voice production.

Terms frequently used to characterize voice disorders involving problems with voice quality, resonance, pitch or loudness include:

Voice quality: hoarseness, wet hoarseness, roughness, strain, harshness, stridency, strangled, tremor, periodicity, breathiness, whisper, glottal attacks, and glottal fry.

Resonance: nasality problems

Vocal Pitch: too low, too high, too little variation (mono-pitch), multiple pitches (e.g., diplophonia), too much variation including pitch breaks.

Loudness: weak, overly loud, inappropriate variations.

**Etiology:** Misuse or improper use/functioning of the vocal mechanism; frequently there is vocal abuse. Sometimes, abnormalities or pathologies of the larynx are present, including but not limited to: nodules, polyps, contact ulcers, papilloma, vocal cord paralysis, bowing of vocal cords, laryngeal edema, chronic laryngitis, and stenosis. Some of the above are the direct result of habitual/chronic misuse of the voice. It is recommended that individuals with voice problems/disorders receive laryngeal examination.

## B. CRITERIA FOR TREATMENT

Speech-voice Assessment/Evaluation by a licensed speech language pathologist or CFY reveals:

1. A voice problem of at least moderate degree,
2. Problems with any two (or more) aspects of voice,
3. No previous voice treatment, or
4. Significant incident necessitating a second treatment regime.

## C. LENGTH OF TREATMENT

Initial Treatment Period (up to 6 months):

1. No prior approval.
2. 30, one-hour sessions.

Additional treatment period after reassessment (up to 3 months for each period):

1. Prior approval.
2. 12, one-hour sessions.

## D. EXCEPTION

A voice problem of mild degree:

Initial Treatment Period (up to 6 months):

1. No prior approval.
2. 12, one-hour sessions.

Additional treatment period after reassessment (up to 2 months for each period):

1. Prior approval
2. 12, one-hour sessions.

# ADULT VOICE DISORDERS
# Related to Laryngeal Cancer

## A. DESCRIPTION

Voice disorders related to laryngeal lesions (cancer) can include total absence of voice or problems of voice quality, pitch or loudness. There can also be breath support/control problems impairing voice production secondary to respiratory disorders or tracheostomy

Additionally, swallowing-eating may be a problem (Refer to Swallowing Disorders).

Terms frequently used to characterize voice problems include:

No voice, aphonia

Voice quality: hoarseness, wet hoarseness, roughness, strain, harshness, stridency, strangled, breathiness, impaired/reduced laryngeal adduction, and glottal fry.

Voice pitch: too low.

Loudness: reduced, weak voice.

**Etiology:** These voice problems occur in conjunction with various laryngeal lesions (cancer); frequently surgery or radiation is required. The surgical procedures include but are not limited to: total laryngectomy and partial laryngectomy; e.g. supraglottic laryngectomy, vertical hemilaryngectomy, hemilaryngectomy, or subtotal laryngectomy.

## B. CRITERIA FOR TREATMENT

Speech-voice Assessment/Evaluation by a licensed speech language pathologist or CFY reveals:

1. No voice (aphonia); or
2. Problems with any two (or more) aspects of voice;
3. A problem of at least a mild to moderate degree; or
4. Swallowing problems (Refer to Swallowing Disorders)
5. No previous voice treatment; or
6. Significant incident necessitating a second treatment regime, e.g. dilatation, TEP.

## C. LENGTH OF TREATMENT

1. No voice (aphonia), related to total laryngectomy

    a. Esophageal Voice Treatment: Traditional*

Initial treatment Period (up to 9 months):

1. No prior approval
2. 45, one-hour sessions

Additional treatment period after reassessment (up to 3 months for each period):

1. No prior approval
2. 14, one-hour sessions

b. Esophageal Voice Treatment: Use of prostheses, e.g., after tracheoesophageal puncture.

Initial Treatment Period (up to 3 months):

1. No prior approval
2. 20, one-hour sessions

Additional treatment period after reassessment (up to 3 months for each period):

1. Prior approval
2. 12, one-hour sessions

c. Esophageal Voice Treatment: Use of an Artificial Larynx, e.g., electrolarynx.

Initial Treatment Period (up to 3 months):

1. No prior approval
2. 12, one-hour sessions

Additional treatment period after reassessment (up to 3 months for each period):

1. Prior approval
2. 12, one-hour sessions

2. Voice problems of quality, pitch, and loudness related to partial laryngectomy.

Initial Treatment Period (up to 3 months):

1. No prior approval
2. 12, one-hour sessions

*Treatment with an artificial larynx and traditional esophageal voice treatment may be occurring at the same time.

Additional treatment period after reassessment (up to 3 months for each period):

1. Prior approval
2. 12, one-hour sessions

# ADULT SPEECH DISORDERS
# Related to Oral Cancer

## A. DESCRIPTION

Speech disorders related to oral cancer involve impairment of speech intelligibility and include problems of articulation, resonance and rate/prosody. Additionally, swallowing-eating problems are frequently present. Terms often used to characterize these speech problems include:

Articulation: imprecise, distorted, reduced clarity, slurred, sound substitutions-compensations/omissions, reduce or poor intelligibility.

Resonance: nasality, other resonance changes because of changes in the oral cavity, nasal air emission/leaks.

Rate/prosody: slow, too fast for present speech mechanism.

Oral-motor proficiency: limited rate, range or strength of movement of the lips, tongue, mandible, velum.

Swallowing-eating, deglutition: slow, nasal regurgitation, reduced oral motility and drooling, increase in oral transit time, impaired pharyngeal phase, reduced swallow reflex, coughing (food entering airway) aspiration.

**Etiology:** These speech and swallowing-eating problems occur in conjunction with various oral lesions (cancer); frequently there has been surgery or radiation. The surgical procedures include but are not limited to: total glossectomy, partial tongue resection/partial glossectomy, composite resection, tongue flaps, palatal-maxillary surgery.

## B. CRITERIA FOR TREATMENT

Speech-voice Assessment/Evaluation by a licensed speech language pathologist or CFY reveals:

1. A speech problem of at least moderate degree,
2. A swallowing-eating problem of a mild degree or worse,
3. No previous speech treatment, or
4. Significant incident necessitating a second treatment regime.

## C. LENGTH OF TREATMENT

Initial treatment Period (3 months):

1. No prior approval.
2. 20, one-hour session

Additional treatment period after reassessment (up to 3 months for each period):

1. Prior approval
2. 15, one-hour sessions

## D. EXCEPTION

For a problem of mild degree:

Initial Treatment Period (2 months):

1. No prior approval.
2. 12, one-hour session.

Additional treatment period after reassessment (up to 2 months for each period):

1. Prior approval.
2. 12, one-hour sessions

# SWALLOWING DISORDERS

## A. DESCRIPTION

Infants, children or adults exhibiting swallowing and feeding disorders including but not limited to the following: pre-maturity, neurological disorders (cerebral palsy, degenerative disease, CVA), oral-motor deficits, oral-sensory deficits, supraglottic laryngectomy or head and neck cancer. One or more of the stages of swallowing may be involved:

Oral: Material place in mouth, lip seal and formation and manipulation of the bolus. This includes mastication. The tongue propelling the bolus posteriorly until the swallow reflex is triggered.

Pharyngeal: Reflexive swallow carries bolus through the pharynx.

Esophageal: Esophageal peristalsis carries bolus through the cervical and thoracic esophagus to the stomach.

## B. CRITERIA FOR TREATMENT

Swallowing evaluation by a licensed speech language pathologist or CFY reveals:

1. Children or adults must have difficulty with one or more stages of swallowing.
2. The child or adult must have inadequate oral intake of solids or liquids for nutrition
3. There must be potential for increasing oral intake.

## C. LENGTH OF TREATMENT

Initial Treatment Period (up to 6 months):

1. No prior approval.
2. 36, one-hour session.

Additional treatment period after reassessment (up to 3 months):

1. Prior approval
2. 18, one-hour session.
3. Evidence that treatment plan was evaluated and revised; evidence of progress; or discharge recommendation.

# PEDIATRIC/CHILDHOOD DISORDERS
# ARTICULATION/PHONOLOGICAL DISORDER

## A. DESCRIPTION

### ARTICULATION/PHONOLOGICAL DISORDER

The inability to produce speech sounds in the language system adequately, thus reducing intelligibility of speech.

**Etiology:** Includes, but is not limited to: trauma, cerebral palsy, apraxia, cleft palate, neuromuscular disorders, hearing impairment, mental retardation, emotional disturbances, recurrent otitis media acquired aberrant behavior patterns, brain tumors, oral trauma, oral cancer requiring surgery.

## B. CRITERIA

Speech Language evaluation by a licensed speech language pathologist or CFY reveals:

1. Articulation/phonological skills fall below those expected for a child's chronological age.
2. Disorder negatively affects overall speech intelligibility

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## C. LENGTH OF TREATMENT

Initial treatment period (up to 6 months):

1. No prior approval
2. 24, one-hour sessions.

Additional treatment period after reassessment (up to 3 months for each period):

1. No prior approval
2. 12, one-hour sessions.

# PEDIATRIC/CHILDHOOD LANGUAGE DISORDERS

## A. DESCRIPTION

Language Disorder will be used here as a broad term to describe certain language behaviors, or lack of the same, in a child that are different from the behavior that might be expected considering the child's chronological age.

**Etiologies** which cause language disorders or put children at risk, include but are not limited to: head injury, brain tumors, CVA, anoxia, seizures, cerebral palsy, cleft palate, mental retardation, meningitis, hearing impairment, chronic otitis media, emotional disturbances, minimal brain dysfunction, environmental deprivation, failure to thrive, bronchopulmonary dysplasia, fetal alcohol syndrome, encephalitis, respiratory dependent, maternal addiction to controlled substance at time of birth.

## B. CRITERIA FOR TREATMENT

Speech Language evaluation by a licensed speech language pathologist or CFY reveals:

1. Language skills fall below those expected for the child's chronological age.
2. Those skills may include auditory comprehension, oral expression/formulation, pragmatics, reading comprehension, cognition, numerical relationships or written expressions.

## C. LENGTH OF TREATMENT

Initial treatment period (up to 6 months):

1. No prior approval.
2. Treatment should begin as soon as the problem is identified.
3. 24, one-hour or 48, ½ hour group or individual treatment session.

Additional treatment period after reassessment (up to 6 months for each period):

1. No prior approval.
2. 24, one-hour or 48, ½ hour group or individual treatment sessions.

Typically, treatment can be expected to be necessary for twelve months or more depending upon the etiology or severity of the disorder.

# PEDIATRIC/CHILDHOOD DISORDERS
# VOICE DISORDERS

## A. DESCRIPTION

Voice Disorders: A term used to refer to defects in one or more aspects of voice production which are related to abnormalities in size, shape, tonicity, surface conditions and muscular control of the phonating and resonating mechanisms.

**Etiology:** These voice problems occur in conjunction with various laryngeal pathologies or abnormalities including but not limited to: disease, trauma, surgery, abuse, stenosis, nodules, polyps, cleft palate, congenital webs, tracheostomy, tracheal malasia, psychogenic reasons.

## B. CRITERIA

One or more aspects of voice is judged to be abnormal as assessed by a licensed speech language pathologist or CFY.

## C. LENGTH OF TREATMENT

Initial treatment period (up to 6 months):

1. No prior approval.
2. Treatment should begin as soon as the problem is identified.
3. 24, one-hour sessions.

Additional treatment prior after reassessment (up to 3 months):

1. Requires prior approval
2. 10, one-hour sessions.

# NONSPEAKING CHILDREN

## A. DESCRIPTION

Non-speaking children: Individuals having no consistent functional means of communications or those individuals who demonstrate inconsistent functional skills in speaking, writing or gestures due to a variety of speech, language and voice disorders.

**Etiology:** includes but is not limited to the following: cerebral palsy, vascular accident, head trauma, brain tumor, spinal cord injury (requiring a trach), muscular dystrophy, respiratory disorders, tracheostomy, mental retardation, autism, deaf or hearing impairment.

## B. CRITERIA FOR TREATMENT

Evaluation by a licensed speech language pathologist or CFY reveals:

1. Speech and Expressive Language Skills

    a. Absence of functional speech and language, or
    b. Markedly reduce intelligibility of speech, and
    c. Nonfunctional written or gesture skills.

2. Cognitive Skills

    a. Fair to good attention, memory, orientation and potential for new learning.
    b. Recognition of symbols, pictures, words, alphabet letters, or numbers, or recognition of gestures and manual signs.

3. Behavior

    a. Cooperative and receptive to treatment
    b. Attempts to communicate to others or displays potential
    c. Not destructive or harmful to self or others

4. Intervention

    a. Intervention requires the utilization of an alternate/augmentative communication system to facilitate further development in communication.

5. Environmental Factors

    a. Family or supportive individuals must be receptive toward the non-speaking individual’s use of an alternative/augmentative communication system (ACS).

b. The existence of education or vocational goals, or has potential for benefiting from educational experience via the introduction of an ACS.

## C. LENGTH OF TREATMENT

Initial treatment period (up to 6 months):

1. No prior approval.
2. Training with a temporary ACS (up to 3 months)
   a) 15, one-hour sessions
3. Training with a permanent ACS (up to 6 months)
   a.) 30, one-hour sessions

Additional treatment period after reassessment (up to 3 months for each period):

1. No prior approval
2. 24, one-hour sessions

Reassessment/Recheck (following discontinuation of formal training):

Periodic rechecks/follow-up session are recommended and conducted in 2 hours of sessions:

1. No prior approval
2. To monitor the patient's use of his ACS
3. To reassess his current communicative needs and capabilities
4. To determine if further upgrading or modification is require
5. To assess with an advance ACS

Prior approval for training with the newly recommended ACS (based on documented results or reassessment/recheck procedures):

1. No prior approval
2. 30, one-hour sessions within a 6-month period
3. Treatment to continue in 12, one-hour session blocks should be granted based on documented progress